DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G010	A. BUILDING _____ B. WING _____	02/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 01	6417 KANSAS AVE, NE WASHINGTON, DC 20001

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W 000	INITIAL COMMENTS A recertification survey was conducted from February 5, 2008 through February 8, 2008. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of five males with various disabilities. The findings of the survey were based on observations, interviews with one client, staff in the home and three day programs, as well as a review of client records, administrative records, and incident reports. Investigation reports were also reviewed.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services met the needs of one of three clients in the sample (Client #2). The findings include: On February 6, 2008 at approximately 10:07 AM Client #2 was observed to spit one time on the floor while entering the class room with his 1:1 staff person. An interview with the Active Treatment Specialist (ATS) at 9:48 AM revealed that spitting was one of Client #2's challenging behaviors. Further interview with the ATS revealed that the day program did not document Client #2's challenging behavior of spitting on the floor on the Antecedent Behavior Consequence (ABC) forms because the documentation was discontinued. There was no communication with the group	W 120	The QMRP will coordinate with the day program to ensure that the BSP is implemented as written, and that data is collected, and reviewed, at all settings as described by the plan.	3/25/08

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2008 FEB 25 P 5:01

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marsha L. Simpson	Director of Disability Services	2/25/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	Continued Fr om page 1 home about the decision discontinue collecting data on this behavior. Interview with the Qualified Mental Retardation Professional QMRP) on February 5, 2008 at approximatel 3:15 PM revealed that the day program was required to documenting each time Client #2 spit as it was a part of his Behavior Support Plan (BSP). Review of Client #2's day program BSP dated August 26, 2007 on February 5, 2008 listed "Spitting on the Floor" as one of his challenging behaviors. Further record review revealed that Client #2's BSP for the facility listed "Spitting on the floor" as a target behaviors and should be documented as it occurs. Review of Client #2's log book kept by the AM 1:1 staff failed to evidence of documentation when the spitting behavior occurred on February 6, 2008 at the day program. It should be noted during medication pass on February 5, 2008 at 5:13 PM Client #2 was administered Hydroxyzine 25 mg. According to the medical record, this medication was prescribed to decrease the client's spitting behavior.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by:	W 124		

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W 124	Continued From page 2 Based on observation, interview and record review, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of four clients residing in the facility. (Client #1, #2 and #3 The findings include: 1. Interview with the evening medication nurse on February 5, 2008 at approximately 5:33 PM revealed that Client #1 was administered Paxil 12.5 mg with Paxil 25 mg each morning for anxiety/depression. Interview with the Qualified Mental Retardation Professional (QMRP) on February 5, 2008 at 3:19 PM revealed that Client #1 had an involved sisters that signs consent for treatment. Review of Client #1's Psychological Assessment on February 7, 2008 at approximately 3:11 PM revealed that the client did not evidence the capacity to make independent decisions on his behalf regarding his habilitation planning, treatment placement, financial, and medical matters. There was no documented evidence that the facility informed Client #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 2. During the medication pass on February 5, 2008 at 5:13 PM, Client #2 was administered Clonazepam 1 mg, Carbamazepine 200 mg, Risperdal 1 mg, and Hydroxyzine 25 mg by	W 124	1. The QMRP will ensure that the client's medical decision-maker is informed in writing of the health benefits and risks of recommended treatments (including the BSP if it provides for restrictive measures), and will obtain written consent for such treatments. 2. See response to #1 above.	3/25/08 3/25/08

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W 124	Continued From page 3 mouth. Interview with the Licensed Practical Nurse (LPN) on the same day at approximately 5:40 PM revealed that the medication was prescribed for maladaptive behaviors. Review of the client's current physicians orders on February 7, 2008 at approximately 9:54 AM revealed that the psychotropic medications was incorporated in a Behavior Support Plan (BSP) dated December 5, 2007, to address behaviors associated with physical aggression (hitting, spitting at, and scratching others), sitting on the floor (at inappropriate times, usually when asked to complete tasks), self-injurious behaviors, property destruction, public masturbation (grabbing genital, smearing feces, and clothes stripping. Interview with the Qualified Mental Retardation Professional (QMRP) on February 5, 2008 at 3:20 PM revealed that Client #2 has an involved mother that signs consent for treatment. Review of Client #2's Psychological Assessment on February 8, 2008 at approximately 9:04 AM revealed that the client did not evidence the capacity to make independent decisions on his behalf regarding his habilitation planning, treatment placement, financial, and medical matters. There was no documented evidence that the facility informed Client #2 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 3. Interview with the evening medication nurse on February 5, 2008 at approximately 5:24 PM revealed that Client #3 is administered Wellbutrin	W 124	3. The QMRP will coordinate with the DDA support coordinator (formerly known as the case manager) to apply for a medical guardian.	3/25/08

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W 124	Continued From page 4 150 mg every morning for depression. Interview with the Qualified Mental Retardation Professional (QMRP) on February 5, 2008 at 3:22 PM revealed that Client #3 was eighty-three years old and did not have a legal guardian and/or family members to give consent for treatment. Review of Client #3's Psychological Assessment on February 6 2008 at approximately 2:37 PM revealed that the client did not evidence the capacity to make decisions on his behalf about treatment, habilitation, on-going medical care, and financial matters. There was no documented evidence that the facility informed Client #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that individuals who lacked the capacity to make informed decisions had received assistance with identifying a surrogate decision-maker for habilitation and treatment needs, for two of four clients residing in the facility. (Client #1,#2 and #3)	W 125	Clients 1 and 2 have medical decision-makers. The QMRP will ensure that they are provided with written information on recommended medical treatments, and that they provide written informed consent for treatments. The QMRP will coordinate with the DDA support coordinator to apply for a medical guardian for client #3.	3/25/08

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W 125	Continued From page 5 The finding includes: The facility failed to ensure Client #1, #2, and #3's rights were protected by making certain each client had a legally sanctioned representative to assist them with making decisions regarding their treatment. [See W124]	W 125		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen. The findings include: 1. Cross refer to W441. The QMRP failed to ensure that held fire evacuation drills quarterly on all shifts. 2. Cross refer to W249. The QMRP failed to staffs implemented programs as outlined in the Individual Program Plans (IPPs). 3. Cross refer to W193. The QMRP failed to staff demonstrated competency in the implementation of Client #5's Behavior Support Plan (BSP). 4. Cross refer to W189. The QMRP failed to	W 159	1. The QMRP will ensure that the Residential Director (RD) will hold and document fire evacuation drills quarterly under varied conditons on all shifts. 2. The QMRP will ensure that staff from both the residence and the day setting are trained to implement each person's IPPs. 3. The QMRP will ensure that staff are trained to effectively implement client #5's BSP. 4. The QMRP will implement training for all staff as needed to enable them to perform their duties effectively, efficiently, and competently.	3/25/08 3/25/08 3/25/08 3/25/08

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W 159	Continued From page 6 ensure that each employee was provided with continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. 5. Cross ref to W436. The QMRP failed to ensure that Client#2 was provided with necessary adaptive equipment (shower chair).	W 159	5. The QMRP will ensure that the client has necessary adaptive equipment.	3/25/08
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The finding includes: 1. The facility failed to ensure that Client #3's soft hand splints were placed on his hands in accordance with the current physician's orders as evidence below: On February 5 2008 at approximately 3:37 PM, Client #3 was observed sitting in a wheelchair with his arms and hands tightly against his body while watching television. At 5:49 PM direct care staff was observed to place hand splints on the client. Interview with Residential Direction (RD) revealed that the hand splints helps with keeping his hands tightly together. Further interview with the RD revealed that the client should wear the	W 169	1. The QMRP will ensure that the RD and staff are trained on the physician's orders on the use of the splints, and ensure that staff implement the orders as written.	3/25/08

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W 189	Continued From page 7 hand splints daily and should be removed by dinner time. Review of the current physician's dated January 2008 on February 6, 2008 at approximately 2:37 PM revealed the client has a diagnosis of Cerebral Palsy with Spastic Quadriplegia, Multiple Flexion Contractures, and Arthritis. Further review of the physician's orders revealed an order for soft hand splints to prevent further contractures. "The soft hand splints should be place on the client's hands in the morning after the morning care from 9:00 AM to 1:00 PM and remove from 1:00 PM to 3:00 PM. Put splints back on from 4:00 PM to 8:00 PM then off." Interview with Qualified Mental Retardation Professional (QMRP) on February 6, 2008 at 3:00 PM revealed that Client #3 was admitted to the facility from another provider on January 31, 2008. When asked if all staff had been trained on the use of Client #3's soft hand splints, the QMRP stated all staff are scheduled to be trained on February 13, 2008. Note: It should be noted that on February 6, 2008 at from 11:03 AM to 12:00 PM Client #3 was not observed to wear his soft hand splints in accordance with the physician's orders. 2. On February 5, 2008 at 5:13 PM Client #2 was administered Senna-S tab for constipation. The client was also prescribed Docusate Sodium 100 mg two capsule daily at bedtime for constipation. According to the bowel tracking chart reviewed on February 8, 2008 at 12:46 PM, Client #2 did not have a bowel movement for three (3) days (2/1, 2/2, and 2/3/08). Review of the Standing Physician's Orders S for "Constipation" revealed the following procedures:	W 189	2. The QMRP will ensure that the RD has a process for checking data collection and reporting errors so that retraining can be implemented as needed. The Director of Disability Services will meet with the QMRP, RD and nursing staff to ensure that a timely and complete communication loop is established and maintained so that nursing staff can properly react to clients' medical needs.	3/25/08

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W 189	Continued From page 8 1. After two days without a bowel movement, give prune Juice 4oz by mouth two times a day for 48 hours or 2. Milk of Magnesia two tablespoon by mouth two times a day PRN or 3. Citrate of Magnesia 4. Push oral fluids Interview with the facility's Licensed Practical Nurse (LPN) confirmed that staff should notify the nurse and give prune juice in accordance with the standing physician orders. Further interview with the LPN revealed that she was not made aware that the client did not have a bowel movement for three days. Interview with the Residential Director revealed that Client #2 had a bowel movement within those days. but staff forgot to record it. 2. Cross refer to W249. The facility failed to ensure that staff had received effective training in implementing programs as outlined in the Individual Program Plans (IPPs).	W 189	2. See response to W249. The QMRP will ensure that all staff are trained on implementation of each client's ISP as soon as the Interdisciplinary Team has formulated it.	3/25/08
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review the facility staff failed to demonstrate competency in the implementation of Client #5's Behavior Support Plan (BSP). The finding includes:	W 193	The QMRP will ensure that all staff adhere to the standards governing the 1:1 staffing duties. Staff who are unwilling or unable to adhere to the requirements will be removed from such duties.	3/25/08

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W 193	Continued From page 9 The facility failed to ensure that Client #5's 1:1 staff remained in close proximity in accordance with the 1:1 job duties and responsibilities as evidence below: On February 7, 2008 at 4:33 PM Client #5 was observed to leave the kitchen area to go outside to stand on the front porch. Client #5's 1:1 staff was in the kitchen preparing the dinner meal. The client remained outside on the porch for two minutes before coming back into the facility. At no time did the 1:1 staff leave the kitchen area to trail or remain within eyesight of Client #5 as required by his behavior management plan. Interview with the Qualified Mental Retardation Professional (QMRP) on February 8, 2008 at approximately 10:00 AM revealed Client #5 received 1:1 staffing 24 hours a day to manage physically aggressive behaviors to prevent elopement and injuring self and others. Further interview with the QMRP revealed that one of the primary duties of the 1:1 staff person was to remain within eyesight and/or arms length of Client #5 at all times. Review of the staff training records on February 8, 2008 at 9:12 AM revealed that all staff signed and received training on their 1:1 job duties and responsibilities. There was no evidence that training was successful.	W 193		
W 247	483.440(c)(6) (vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that Client #2 was provided the	W 247	The QMRP will ensure that staff are retrained on engaging client #2 in self management and offering opportunities for self directed activities.	3/25/08

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W 247	Continued From page 10 opportunities for making choices as part of their self-management. The finding includes: Evening observations conducted on February 5, 2008 at approximately 4:16 PM revealed Client #2's 1:1 staff organizing his close in his bedroom. Client #2 was observed to be sleeping while sitting in the chair at the front of the bed. Interview with the 1:1 staff revealed that Client #2 normally assists with folding laundry and straightening out his closet. The 1:1 stated that Client #2 required hand over hand assistance with this task due to his blindness. At no time did the 1:1 staff offer or encourage Client #2 to assist with organizing his closet. There was no evidence that the Client #2 was afforded the opportunity for self-management to the extent of his capabilities.	W 247		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement programs as outlined in the Individual Program Plans (IPPs), for one of three clients included in the sample. (Client #3)	W 249	The QMRP will ensure that staff in the residence are effectively trained in implementing client #1's IPPs, and that residential staff ensure that he is encouraged to improve his self management skills.	3/25/08

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W 249	Continued From page 11 The finding includes: On February 5, 2008 at approximately 6:22 PM Client #1 was served sweet potatoes, roasted turkey breast, collard greens, and beverage pureed during his dinner meal. The client was observed to receive total assistance from his 1:1 staff person. Interview with the 1:1 staff revealed that the client is totally dependent with feeding and his ADL skills. On February 8, 2008 at 12:11 PM the client was observed during lunch at his day program. The client was served mixed vegetable, baked fish, and wheat bread pureed. The assigned 1:1 staff was observed to feed Client #1 using hand over hand assistance and encouraging him to raise the spoonful of food to his mouth during the entire meal. Interview with the 1:1 staff at the day program revealed that she was trained to feed Client #5 using hand over hand assistance. The 1:1 staff further revealed that Client #5 had an objective to raise his spoon with food to his mouth with hand over hand assistance. Review of Client #1's Individual Program Plan (IPP) dated January 24, 2008 on February 7, 2008 at approximately 3:11 PM revealed a program that stated "with hand over hand assistance, the client will raise his spoon filled with food to his mouth three times with 100% accuracy for 6 consecutive months." There was no evidence that the Client #1 was afforded the opportunity for self-management and encouraged to participate in his programs during the dinner meal on February 5, 2008.	W 249		
W 263	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE	W 263		

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W 263	Continued From page 12 The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consents, for three of three clients included in the sample. (Client #1, #2, and #3) The findings include: 1. [Cross Reference W124] The facility's human rights committee failed to ensure that informed consent had been obtained for the use of Behavior Support Plan (BSP) that incorporated the use of prescribed psychotropic medications. Interview with Qualified Mental Retardation Professional (QMRP) on February 8, 2008 at approximately 1:30 PM revealed that Client #1 did not have written informed consent signed by a guardian. It should noted, according to the QMRP, the client's sisters is " involved" in his life, but there was no evidence that they had been informed of the use of psychotropic medications. 2. [Cross Reference W124] The facility's human rights committee failed to ensure that informed consent had been obtained for the use of Behavior Support Plan (BSP) that incorporated the use of prescribed psychotropic medications. Interview with Qualified Mental Retardation Professional (QMRP) on February 8, 2008 at approximately 1:32 PM revealed that Client #2 did	W 263	1. See response to W124. The Human Rights Committee has a procedure to review the use of all restrictive measures, including the use of psychotropic medicines; the QMRP will ensure that such restrictive treatments for client #1 are brought before the HRC for approval. 2. See response to #1 above.	3/25/08 3/25/08

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W 263	Continued From page 13 not have written informed consent signed by a guardian. It should noted, according to the QMRP, the client's mother is " involved" in his life, but there was no evidence that they had been informed of the use of psychotropic medications. 3. [Cross Reference W124] The facility's human rights committee failed to ensure that informed consent had been obtained for the use of Behavior Support Plan (BSP) that incorporated the use of prescribed psychotropic medications. Interview with Qualified Mental Retardation Professional (QMRP) on February 8, 2008 at approximately 1:34 PM revealed that Clients #3 did not have written informed consent signed by a guardian. There was no evidence that they had been informed of the use of psychotropic medications.	W 263	3. See response to #1 above.	3/25/08
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure general and preventive care for two of three clients included in the sample. (Client #2 and #3) The findings include: 1. Review of Client #2's current physician's orders on February 7, 2008 at approximately 9:54 AM revealed the client was prescribed a "Cervical Collar" as part of his adaptive equipment. Interview with the facility's Licensed Piratical Nurse (LPN) and Qualified Mental Retardation	W 322	1. The QMRP will ensure that the purpose, recommendations and length of time the client should use the cervical collar is clearly stated in his ISP. The QMRP will ensure that the staff receive training on how to implement and document the use of the cervical collar, and that the nursing staff have a protocol for monitoring the implementation of the neck support.	3/25/08

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W 322	Continued From page 14 Professional (QMRP) on February 8, 2008 at approximately 10:00 AM revealed that the client should wear the cervical collar during bedtime only. Review of Client #2's Individual Support Plan (ISP) amended December 20, 2007 under the section entitled "My assistive Devices", revealed that the cervical collar was to be worn at bedtime and when in the facility. Further interview with the QMRP revealed that the client refused to wear the collar inside the facility. He will take it off. The QMRP stated that it was her mistake of not addressing this issue to the Interdisciplinary Team (IDT) this past ISP and having staff to document his refusals to wear the collar while in the facility. Review of the Physical Therapy assessment dated October 12, 2007 failed to reflect the purpose, recommendations and length of time for the use of the collar. The assessment failed to provide instructions for direct care staff to ensure appropriate implementation for this prescribed support. Further review failed to revealed that a protocol had been developed by the nursing staff and that no documentation was available to support the nursing staff monitoring the implementation of this neck support for Client #2. 2. The facility failed to ensure that Client #3's soft hand splints were worn in accordance with the current physician's orders as evidence below: On February , 2008 at approximately 3:37 PM, Client #3 was observed sitting in a wheelchair with his arms and hands tightly against his body while watching television. At 5:49 PM direct care staff was observed to place hand splints on the client. Interview with Residential Direction (RD) revealed that the hand splints helps with keeping his hands tightly together. Further interview with	W 322	2. See response to W189 #1.	3/25/08

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W 322	Continued From page 15 the RD revealed that the client should wear the hand splints daily and should be removed by dinner time. Review of the current physician's dated January 2008 on February 6, 2008 at approximately 2:37 PM revealed the client has a diagnosis of Cerebral Palsy with Spastic Quadriplegia, Multiple Flexion Contractures, and Arthritis. Further review of the physician's orders revealed an order for soft hand splints to prevent further contractures. "The soft hand splints should be place on the client's hands in the morning after the morning care from 9:00 AM to 1:00 PM and remove from 1:00 PM to 3:00 PM. Put splints back on from 4:00 PM to 8:00 PM then off." Interview with Qualified Mental Retardation Professional (QMRP) on February 6, 2008 at 3:00 PM revealed that Client #3 was admitted to the facility from another provider on January 31, 2008. When asked if all staff had been trained on the use of Client #3's soft hand splints by the Nurse, the QMRP stated all staff are scheduled to be trained on February 13, 2008.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of two clients in the sample. (Client #1 and Client #2) The finding includes: Cross refer to W322.2. The facility's nursing staff	W 331	See response to W189.	3/25/08

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W 331	Continued From page 16 failed to ensure that Client #3's soft hand splints were worn in accordance with the current physician's orders.	W 331		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by:	W 356	The QMRP will coordinate with the medical team to ensure that clients receive comprehensive dental treatment services.	3/25/08
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that Client#2 was provided with necessary adaptive equipment (shower chair). The finding includes: Observations conducted on February 5, 2008 revealed Client #2 was blind and required assistance with mobility and Adaptive Living Skills (ADL). Interview with his assigned 1:1 staff on February 6, 2008 at 3:01 PM revealed that Client #2 is able to complete some ADL skills with hand	W 436	The QMRP will ensure that the client has a shower chair as recommended in the PT assessment	3/25/08

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W 436	Continued From page 17 over hand assistance including toothbrushing, putting on clothes, washing/drying hand, and showers. Record review on February 7, 2008 at approximately 10:30 AM revealed a Physical Therapy (PT) Assessment dated October 12, 2007. According to the assessment, it was recommended that Client #2 utilize a grab bars and a shower chair to assist with showering. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 4:25 PM revealed that Client #2 did not have a shower chair. There was no documented evidence that Client #1 was provided with the shower chair to assist with showering as recommended in the PT assessment.	W 436		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record verification, the facility failed to hold evacuation drills under varied conditions. The finding includes: Review of the facility's fire drill records on February 6, 2008 at 1:16 PM revealed that the fire drills were conducted via the front and back door exits. Interview with the Qualified Mental Retardation Professional (QMRMP) on the same day at 2:10 PM revealed that the facility had at least five method of egress. Further interview with the QMRP revealed that there's an exit through the kitchen (Side Door) and exit on the upper level of the facility leading to the back yard. Further review of the fire drill record revealed that	W 441	The QMRP will ensure that the RD holds fire evacuation drills on all shifts at least quarterly under varied conditions.	3/25/08

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W 441	Continued From page 18 the side door exit and the exit on the upper level had not been used at least quarterly on each shift. There was no evidence that evacuation drills were held under varied conditions.	W 441		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure therapeutic diets addressed the nutritional needs of one of two clients in the sample. (Client #2) The finding includes: On February 5, 2008 at approximately 6:22 PM Client #2 was served sweet potatoes, roasted turkey breast, collard greens, and water as his beverage during the dinner meal. The staff preparing the meal did not measure the food portions that was served to Client #2. Interview with the staff at approximately 6:15 PM revealed that Client #2 is on a special diet. When asked how do you know what amount of portions to give to Client #2, the staff stated "I just know, I've been doing this for a long time." Review of the current physician's orders on February 7, 2008 at approximately 9:54 AM revealed that Client #2 was prescribed a 1800 calorie low fat, low cholesterol, chopped diet. Review of the Nutritionist's assessment revealed that Client #2 was prescribed a 1800 calorie low fat, low cholesterol, chopped diet. There was no evidence that the staff measured the food	W 460	The QMRP will ensure that staff are trained to properly and accurately measure the client's food servings so that his diet conforms to the diet recommended by the Nutritionist.	3/25/08

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W 460	Continued From page 19 portions that were served to the client in order to meet his dietary needs.	W 460		

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I 000	INITIAL COMMENTS A licensure survey was conducted from February 5, 2008 through February 8, 2008. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of five males with various disabilities. The findings of the survey were based on observations, interviews with one client, staff in the home and three day programs, as well as a review of client records, administrative records, and incident reports. Investigation reports were also reviewed.	I 000		
I 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by; Based on observation, interview, and record review, the GI IMRP failed to ensure therapeutic diets addressed the nutritional needs of one of two clients in the sample. (Resident #2) The finding includes: On February 7, 2008 at approximately 6:22 PM Resident #2 was served sweet potatoes, roasted turkey breast, collard greens, and water as his beverage during the dinner meal. The staff preparing the meal did not measure the food portions that were served to Resident #2. Interview with the staff at approximately 6:16 PM revealed that Resident #2 is on a special diet. When asked how do you know what amount of portions to give to Resident #2, the staff stated "I just know, I've been doing this for a long time,"	I 042	The QMRP will ensure that staff are trained to properly and accurately measure the client's food servings so that his diet conforms to the diet recommended by the Nutritionist.	3/25/08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director of Disability Services — (X6) DATE: 2/25/08

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I 042	Continued From page 1 Review of the current physician's orders on February 7, 2008 at approximately 9:54 AM revealed that Resident #2 was prescribed a 1800 calorie low fat, low cholesterol, chopped diet. Review of the Nutritionist's assessment revealed that Resident #2 was prescribed a 1800 calorie low fat, low cholesterol, chopped diet. There was no evidence that the staff measured the food portions that were served to the client in order to meet her dietary needs.	I 042		
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to maintain the interior and exterior of the GHMRP in a safe, clean, orderly, attractive, and sanitary manner. The finding includes: Observation and interview with the Qualified Mental Retardation Professional (QMRP) during the environmental walk through on February 8, 2008 revealed that the door bell located at the front of the home was observed not functioning.	I 091	The QMRP will ensure that the doorbell is repaired or replaced.	3/25/08
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.	I 135	The QMRP will ensure that the RD holds fire evacuation drills on all shifts at least quarterly under varied conditions.	3/25/08

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I 135	Continued From page 2 This Statute is not met as evidenced by: Based on observations, staff interview, and record verification, the GHMRP failed to hold evacuation drills under varied conditions. The finding includes: Review of the facility's fire drill records on February 6, 2008 at 1:15 PM revealed that the fire drills were conducted via the front and back door exits. Interview with the Qualified Mental Retardation Professional (QMRMP) on the same day at 2:10 PM revealed that the facility had at least five method of egress. Further interview with the QMRP revealed that there's an exit through the kitchen (Side Door) and exit on the upper level of the facility leading to the back yard. Further review of the fire drill record revealed that the side door exit and the exit on the upper level had not been used at least quarterly on each shift. There was no evidence that evacuation drills were held under varied conditions.	I 135		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff had current health certifications on file.	I 206		

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I 206	Continued From page 3 The findings include: 1. Review of the personnel files conducted on February 8, 2008 at approximately 9:12 PM revealed the GHMRP failed to provide evidence of current current health certificates for one staff. (S #4)	I 206	1. The Human Resources Director will ensure that Staff #4 has a current health certificate on file.	3/25/08
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in first Aid and CPR for employees. The findings include: On February 8, 2008, review of personnel records/training records revealed that the following staffs were without current First Aid and CPR, or both. 1. Current CPR - S #4 and S #16	I 227	1. The Human Resources Director will ensure that Staff #4 and #16 have evidence of current CPR on file.	3/25/08
I 392	3520.2(b) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The	I 392		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 392	Continued From page 4 professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services; (b) Dentistry. This Statute is not met as evidenced by: Based on observations, interview, and record review, the QMRP failed to ensure comprehensive treatment services for the maintenance of dental health for two of three residents in the sample. (Client #1 and #2) The findings include: 1. Review of Resident #2's medical records on February 7, 2008 at approximately 11:04 AM revealed a dental consult dated September 19, 2007. The consult was the follow up from the October 3, 2006 dental appointment. The dentist findings was moderate calculus deposits and recommended patient needs scaling "will submit pre-authorization to Medicaid for approval." Interview with the Qualified Mental Retardation Professional (QMRP) and facility's Licensed Practical Nurse (LPN) on February 8, 2008 at approximately 1:10 PM confirmed that Resident #1 had not been back to the dentist since October 3, 2006 almost a year later. The QMRP stated that the facility was still waiting for approval for dental services (Scaling) and that she was following up with this issue. At the time of the survey, the facility failed to provide evidence that Resident #1 received timely dental services. There was also no evidence of the facility's efforts to assist with the obtainment of the pre-authorization.	I 392	1. The QMRP will coordinate with the DDA Support Coordinator to acquire the prior authorization required for Medicaid payment for dental services on a timely basis, and that the dentist also provides an appointment for the client within the prior authorization period.	3/25/08

PF INTED: 02/15/2008
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G010	A. BUILDING _____ B. WING _____	02/08/2008

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I 392	Continued From page 5 2. On February 5, 2008 at approximately 3:36 PM Resident #2 was observed to have discoloration around his teeth. Review of Resident #2's medical records on February 7, 2008 at approximately 9:54 AM revealed a dental consult dated December 4, 2006. According to the consult, the dentist recommended scaling due heavy moderate calculus deposits, and indicated she"will submit pre-authorization to Medicaid for approval." Further record review revealed another dental consult dated November 6, 2007. According to the consult, there was slight mobility with teeth #10 and moderate calculus deposits noted. The dentist recommended scaling and "will submit pre-authorization to Medicaid for approval." Interview with the Qualified Mental Retardation Professional (QMRP) and facility's Licensed Practical Nurse (LPN) on February 8, 2008 at approximately 1:00 PM confirmed that Resident #2 had not been back to the dentist since December 4, 2006 almost a year later. The QMRP stated that the facility was still waiting for approval for dental services (Scaling) and that she was following up with this issue. At the time of the survey, the facility failed to provide evidence that Resident #1 received timely dental services. There was also no evidence of the facility's efforts to assist with the obtainment of the pre-authorization.	I 392	2. See response to #1 above.	3/25/08
I 394	3520.2(d) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be	I 394	See response to I042.	3/25/08

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I 394	Continued From page 6 limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (d) Nutrition; This Statute is not met as evidenced by: The GHMRP failed to ensure that qualified professional staff carried out and monitored necessary professional interventions, in accordance with clients needs, the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The finding includes: On February 5, 2008 at approximately 6:22 PM Resident #2 was served sweet potatoes, roasted turkey breast, collard greens, and water as his beverage during the dinner meal. The staff preparing the meal did not measure the food portions that was served to Resident #2. Interview with the staff at approximately 6:15 PM revealed that Resident #2 is on a special diet. When asked how do you know what amount of portions to give to Resident #2, the staff stated "I just know, I've been doing this for a long time." Review of the current physician's orders on February 7, 2008 at approximately 9:54 AM revealed that Resident #2 was prescribed a 1800 calorie low fat, low cholesterol, chopped diet. Review of the Nutritionist's assessment revealed that Resident #2 was prescribed a 1800 calorie low fat, low cholesterol, chopped diet. There was no evidence that the staff measured the food portions that were served to the resident in order to meet his dietary needs.	I 394		

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I 395	Continued From page 7	I 395		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISION: Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: The GHMRP failed to ensure that qualified professional staff carried out and monitored necessary professional interventions, in accordance with clients needs, the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team for two of three residents included in the sample. (Resident #2 and #3) The findings include: 1. Cross refer to 322.1. Review of Client #2's current physician's orders on February 7, 2008 at approximately 9:54 AM revealed the client was prescribed a "Cervical Collar" as part of his adaptive equipment. Interview with the facility's Licensed Practical Nurse (LPN) and Qualified Mental Retardation Professional (QMRP) on February 8, 2008 at approximately 10:00 AM revealed that the client should wear the cervical collar during bedtime only. Review of Client #2's Individual Support Plan (ISP) amended	I 395	1. The QMRP will ensure that the purpose recommendations and length of time the client should use the cervical collar is clearly stated in his ISP. The QMRP will ensure that the staff receive training on how to implement and document the use of the cervical collar, and that the nursing staff have a protocol for monitoring the implementation of the neck support.	3/25/08

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I 395	Continued From page 8 December 20 2007 under the section entitled "My assistive Devices", revealed that the cervical collar is to be worn at bedtime and when in the facility. Further interview with the QMRP revealed that he client will not wear the collar Inside the facility. He will take it off. The QMRP stated that it was her mistake of not addressing this issue to the Interdisciplinary Team (IDT) this past ISP and having staff to document his refusals to wear the collar while in the facility. Review of the Physical Therapy assessment dated October 12, 2007 failed to reflect the purpose, recommendations and length of time for the use of the collar. The assessment failed to provide instructions for direct care staff to ensure appropriate implementation for this prescribed support. Further review failed to revealed that a protocol had been developed by the nursing staff and that no documentation was available to support the nursing staff monitoring of the implementation of this neck support for Client #2. 2. Cross refer to 322.2. The facility failed to ensure that Client #3's soft hand splints were worn in accordance with the current physician's orders.	I 395	2. The QMRP will ensure that the RD and staff are trained on the physician's orders on the use of the splints, and ensure that staff implement the orders as written.	3/25/08
I 422	3521.3 HABILITATION AND TRAINING Each GHMRF shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement programs as outlined in the Individual Program Plans (IPPs), for one of three clients included in the sample. (Resident #3)	I 422	The QMRP will ensure that staff in the residence are effectively trained in implementing client #1's IPPs, and that residential staff ensure that he is encouraged to improve his self management skills.	3/25/08

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I 422	Continued From page 9 The finding includes: On February 8, 2008 at approximately 6:22 PM Resident #1 was served sweet potatoes, roasted turkey breast, collard greens, and beverage pureed during his dinner meal. The resident was observed to receive total assistance from his 1:1 staff person. Interview with the 1:1 staff revealed that the client is totally dependent with feeding and his ADL skills. Observations of the lunch meal at the day program on February 8, 2008 at 12:11 PM the resident was served mixed vegetable, baked fish, and wheat bread pureed. The assigned 1:1 staff was observed to feed Resident #1 with hand over hand assistance an encourage him to raise the spoon filled with food to his mouth during the entire meal. Interview with the 1:1 staff at the day program revealed that she was trained to feed Resident #5 with hand over hand assistance. The 1:1 staff further revealed that Resident #5 has an objective to raise his spoon with food to his mouth with hand over hand assistance. Review of Resident #1's Individual Program Plan (IPP) dated January 24, 2008 on February 7, 2008 at approximately 3:11 PM revealed a program that stated "with hand over hand assistance, the client will raise his spoon filled with food to his mouth three times with 100% accuracy for 6 consecutive months." There was no evidence that the Resident #1 was afforded the opportunity for self-management and encouraged to participate in his programs during the dinner meal on February 6, 2008.	I 422		

CARECO
HEALTH CARE PROVIDERS
8115 FENTON ST., SUITE 203 SILVER SPRING, MD 20910
(301) 565-9400 FAX (301) 565-4541

TO: Michael D. Walker
Sharon Mebane
Patricia Vanburen

FR: Marsha Thompson

DT: Feb. 25, 2008

RE: Plan of Correction

Hi, Al :

Please see the attached POC for Careco 01, located at 6417 Kansas Avenue, NE DC 20001

This P OC is being transmitted to you via fax.